EDITORIAL / VAN DIE REDAKSIE

Welcome back

As many of our authors are told by the editor, the *SAMJ* has limited space, and often articles require shortening if they are to have any chance of being accepted for publication. It may therefore seem strange that in this issue of the *SAMJ* we appear to be going against our own policy by devoting over 4 pages to a talk given at the University of Cape Town on 22 June 1993, particularly since papers intended for oral delivery are often not suitable for publication in the medium of print.

The reason for the apparent disregard of our usual practice is that the speaker was Sir Raymond Hoffenberg, and his subject was 'Doctors and society'. The importance and relevance to the South African medical profession of what he had to say on that occasion led to a decision to publish his talk, and because of the significance of the occasion to publish it practically in full.

Sir Raymond Hoffenberg is well placed to give a talk on 'Doctors and society', with particular reference to the profession in South Africa. A staunch upholder of the principles of academic equity for all races in South Africa and a bitter opponent of apartheid, he was banned in 1968, and the terms of this order were so restrictive that he was forced to leave this country. A measure of his stature is that having taken up residence in the UK, he eventually became President of the Royal College of Physicians of London and President of Wolfson College, Oxford. What was most remarkable about his talk was that there was no apparent bitterness, although he had good reason to be bitter, and no attempt to pay back old scores, although he could certainly have done so. Instead, his talk concentrated on the ethical principles of our profession which had in the past become so sadly compromised, and without which our profession still runs a grave risk of sinking into being a mere trade or business.

It is tempting to speculate on the contribution Bill Hoffenberg might have made to medicine in South Africa had he been allowed to stay here. However, even though his recent stay was all too short, I shall simply confine myself to saying – welcome back!

N. C. LEE
Emeritus Editor

Doctors and society — the Biko Lecture

It is nice to be back. When I left over 25 years ago, I expected never to return, as I left on an exit permit and did not foresee the change of circumstances that would allow me re-entry. I now advise you all to go away for 25 years and then to come back, just for the immense pleasure of doing so.

To my great regret I never knew Steve Biko; he appeared on the scene just as I was retiring from it. But, as Chairman of the Advisory Board of NUSAS I remember the effect he had in 1967 at the time of its annual meeting at Rhodes University when he challenged the imposed separate residential requirements, and I recall the discussions that took place when he and Barney Pityana founded SASO, not conceived as an anti-white student organisation — or anti-NUSAS, simply as a black organisation more appropriate to represent the views of black students. I was aware at the time that NUSAS held Steve Biko and his opinions in the highest regard, and I am, of course, familiar with his life and at least some of his writings. I feel honoured to help to commemorate him this evening.

The manner of his death shocked the world and his name has become a symbol of South African oppression in the same way as 'Sharpeville'. It brought into lurid relief the brutality and inhumanity of the security police and the system they represented.

As a subtheme in this ghastly story there was the behaviour of the Biko doctors — Lang, Tucker, and one or two others who seem lucky to have escaped closer scrutiny. I shall return to them in the context of the broader subject I wish to discuss this evening: the role of doctors in society; their responsibilities to individual patients on one hand and to society on the other; and the dilemma that arises at times when there is a conflicting interest between these two responsibilities.

The standing of doctors in society — and therefore the influence they have been able to exert — has changed over the centuries. In the Middle Ages doctors were understandably held in very low esteem. First, because medicine had no defined rational or scientific base; it was compounded of magic, superstition and metaphysics with a flavour of religion. There was little reason for the public to respect doctors for the skill and learning they possessed. Second, the lack of regulation of doctors — no training requirements, no testing, no certification — allowed easy infiltration by quacks and charlatans of all descriptions. The public found it difficult to distinguish the real thing from the bogus and devised ways of testing their medical attendants by attempting to deceive them.

Naked-eye examination of the urine was at the time an integral part of the diagnostic process, and the doctor was meant to infer from this not only the nature of the illness, but the age and sex of the patient. It was not uncommon for someone else's urine to be substituted — or that of an animal — to test whether the doctor knew his stuff. Texts of the time advised doctors how to overcome such challenges and I quote from one:[1] 'Very possibly you gather nothing from inspection of the urine; very well, then, say the patient is suffering from obstruction of the liver. Be sure to use the word "obstruction" for they don't understand it, and it is often exceedingly useful that people should not understand what you say.'

Although Hippocrates tried to suggest that medicine was a science, we can skip through the centuries and the long dominant influence of Galen to the Renaissance before we find the first real attempts to establish a scientific basis for medical practice. The 16th century anatomical studies of Vesalius were followed by Harvey's demonstration of the circulation and, in relatively quick succession, scientists like Malpighi and van Leeuwenhoek inspired the great clinicians — Boerhaave and the Scottish School stand out — to introduce scientific concepts into practice. New respect for medicine began to emerge.

This was greatly enhanced by the simultaneous efforts of the medical profession to regulate itself, by setting entry requirements, establishing standards of practice and introducing certification. In Britain the Royal College of Physicians, founded in 1518, initiated these ideas. The public could now distinguish the professional from the impostor, the trained practitioner from the charlatan.

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The status of doctors began to change. Suspicion and mistrust gave way to respect and confidence and doctors began to enjoy some recognition in society of their learning and professionalism. (Surgeons and apothecaries lagged behind physicians — thus deference was paid to 'the profession of physic' but less flattering reference was made to 'the craft of surgery' and 'the apothecary's trade'.)

Respect for doctors — and its lack

By the beginning of this century doctors in Britain enjoyed considerable prestige. The great physicians and surgeons of the time became fashionable, treated royalty, gained wealth and influence — and authority. When authority merged into authoritarianism critical voices began to be heard. One of the most trenchant was that of G. B. Shaw who, in his preface to *The Doctors' Dilemma* in 1920, wrote: '. . . the medical profession has not a high character; it has an infamous character. I do not know a single thoughtful and well-informed person who does not feel that the tragedy of illness at present is that it delivers you helplessly into the hands of a profession which you deeply mistrust . . .'.

Notwithstanding, the reputation of doctors continued to climb. Paul Starr[2] in *The Social Transformation of American Medicine* recognised that the medical profession has an especially persuasive claim to authority. First, because — unlike the law and the clergy — it enjoys close bonds with medical science (and science has a special place in our society); second, because doctors are brought into direct and intimate contact with people and 'are present at the critical transitional moments of existence'. 'The very circumstances of sickness promote acceptance of their judgement.' Patients reveal to doctors details of their personal lives, their habits, their weaknesses, their fears and anxieties, and expect these to be treated in confidence; they receive from doctors advice about the way they conduct their lives — about smoking and drinking, their sexual practices, their food, their jobs, and their interpersonal relationships. This exchange of intimate detail can only take place if patients respect their doctors; they need to hold them in high regard.

Despite this inherent advantage, and despite the spectacular advances and benefits that medical science has brought over the past 50 years, there has been a detectable recent decline in the status of the profession, particularly in the USA. There, the public has begun to demand a greater say, not only in their own individual clinical decisions, but in broader problems of the nature of health services and their distribution. In part this is due to genuine dissatisfaction with the services provided by doctors, often seen to be non-communicative, arrogant, uncaring and impersonal; in part, it results from the new commercialisation of medicine — patients being called 'clients' or 'consumers', health professionals 'purveyors', consultations 'clinical transactions'; and, above all in the USA, the dominance of institutional profit-making and the recognised profusion of unashamed excessively acquisitive doctors. (As an aside, why not 'patient'? It is a perfectly good word, derived from *patientem,* the present participle of *pati,* to suffer. Don't most people seek medical advice because they are suffering? And is it not our job to relieve suffering? Why are we persuaded to call them 'clients' and 'customers'?) Even in Britain with its nationalised health service, the introduction of competitive marketing has placed an emphasis on value for money, on financial viability rather than standards of care — a shift that has not escaped the public eye — and some have begun to question the motives behind medical decisions. When doctors suggest that a certain treatment is inappropriate, is this based on their clinical judgement or pecuniary interest? Once this conflict of interests becomes apparent to the patient, there is erosion of an essential feature of good clinical practice — trust. Without this we return to the era of doubt and suspicion that dominated medicine in the middle ages. This, I fear, is happening in the USA and explains, in part, the high prevalence of litigation there.

To let die — personal choice or legal constraint?

In this atmosphere of doubt, doctors are no longer seen as the patients' advocate, putting *their* interests above all others. Particularly in matters of life and death the hegemony of doctors has been challenged. Whereas at one time doctors were free to decide — and their decisions were not questioned — that a badly deformed newborn baby should be allowed to die or that an elderly patient should not be resuscitated or that a life support system should be switched off, today such decisions often require the consent of patients, relatives, hospital authorities and, at times, courts of law. We saw this recently in Britain in the case of Tony Bland, a young man who had been in a persistent vegetative state since being injured when a football stadium collapsed some 3½ years ago. After considering a petition from his parents, the Law Lords agreed to allow his feeding tubes to be removed, and Tony Bland was allowed slowly to die. In their judgement, the Lords warned that future similar cases should not be decided by doctors, that each decision needed the authority of the law. It is probably a reflection of my age but I would still prefer — on humanitarian grounds — to have such decisions left in medical hands, preferably in the way it has, up to now, been done in Britain — quietly, unobtrusively, unstated, unacknowledged and, usually, unchallenged. A forlorn hope, I fear, in our new open society.

This openness does introduce conflicts, especially when the law and medical practice come into collision. Recently in Britain a physician, Dr Nigel Cox, injected potassium chloride to end the life of a patient, Mrs Lilian Boyes, who was dying a slow, painful and horribly undignified death and who had refused all treatment and consistently asked to be put out of her misery. Cox, a compassionate devoted doctor, did what many of us — and a majority of the public — would agree was the right thing in this complex and harrowing case, but he transgressed a basic law of society — thou shalt not kill — and was found guilty of attempted murder. In his summing up the Judge said, 'What you did was not only criminal, it was a total betrayal of your unequivocal duty as a physician.'

I suspect he had in mind the Hippocratic oath which says, 'I will give no deadly medicine to anyone if asked.' Leaving aside the fact that doctors in Britain have not taken this oath for many years, many physicians, and most patients, would not agree that Cox's action was a total betrayal of his duty. In the Netherlands, where euthanasia is widely practised, accounting perhaps for 2% of all deaths, surveys have shown that 70 - 80% of the public welcome the fact that many, but not all, doctors accept this responsibility and it has not led to a discernible erosion of trust and confidence in the profession. In this regard in Britain the public and the law are at variance and the medical profession is uncertain about its own role. Doctors have a moral obligation to try to provide peaceful, dignified, humane death with minimal suffering. They have no obligation to do more — in fact, they are precluded by law from doing so — Cox was lucky to have escaped a prison sentence. The charge against him was altered from murder to attempted murder because the death of Mrs Boyes was imminent and there was some uncertainty whether the

potassium chloride had actually killed her. Had he been found guilty of the former he would have faced a mandatory life sentence; in Britain this always means at least 5 years in prison, almost always 10. There is an unresolved dichotomy between the legal decisions that allow doctors to let death occur slowly, as with Tony Bland, but not to accelerate it, as with Dr Cox and Mrs Boyes.

In the field of medical research this same public constraint is exercised. Codes of practice have been formulated by all developed countries and there is increasing monitoring of research by designated organisations with substantial, if not majority, lay representation. It is worth remarking that the development of ethical guidelines for human research has been led by medical scientists in recent years; the biomedical research community today is well aware of the consequences of its endeavours and its responsibility to society. It does not need regulating, it knows better than the public how the implications of scientific pursuit might affect society and is at least as anxious as the public to ensure that abuse of scientific knowledge is contained. Dr Strangelove was a fictional character, so was Frankenstein. Real-life scientists today are conscientious, concerned and fully aware of their responsibilities. It wasn't always like this. In the last century the use of hospital patients as guineapigs was considered legitimate by visiting physicians who often carried out horrendous experiments on them — without explanation, without consent and without any form of accountability. In 1879 Neisser discovered the gonococcus and surmised that it caused gonorrhoea. To prove this required the inoculation of human subjects with the organism, as there was at the time no known animal vector. To his great credit, Neisser made the correct ethical decision, declined to carry out the required human experiment and preferred to remain in doubt. Within a few years, however, colleagues in Germany had carried out the crucial experiments and showed that his assumption was correct. What followed was of interest. The German government and the public were deeply offended by the callousness of Neisser's colleagues and in 1900 the Prussian government issued a proclamation about human experimentation that could stand today as a model of ethical correctitude. In most developed countries mechanisms have been set up to deal with other difficult ethical issues, such as *in vitro* fertilisation, research on embryos, the use of fetal tissues or genetic manipulation. It is perfectly proper for the public to have a greater say in such matters, for doctors and medical scientists to act more in an advisory role. Decisions about such difficult issues are not simply a medical prerogative.

Rationing health care

Similar confiicts arise when a doctor's clinical freedom to do what he regards as best for his patient is curtailed by other constraints, such as lack of resources. Increasingly, developed countries are finding it impossible to offer the best available medicine to all of their people at all times, and choices have to be made. Should these be left to the medical profession, to exercise a form of triage in deciding which patient gets what treatment? Or should the public, acting through government or not, dictate such decisions to the profession? The many debates on this topic that have taken place in Britain in recent years have shown confusion between the determination of priorities (in the Oregon fashion) and the imposition of rationing (the deliberate withholding of certain beneficial services, usually because of lack of resources, mainly money). I contend that the former is a function of society and should be based on wide public consultation, with appropriate medical guidance as was accomplished in Oregon; the latter (rationing) is not a medical function; nor is it a public function. It is, very clearly, a policy decision to be taken by government. If government wishes to withhold or withdraw a service that is known to be of value, it should state clearly that it will no longer be available on public funds and be prepared, if necessary, to face public — or professional — objections. Doctors should not be expected to act as government's or society's agents in the rationing process. A curious twist to this problem emerged recently in Britain when a group of surgeons decided they would not perform certain elective procedures on patients who smoked, a decision that has given rise to much discussion. If it was based on clinical judgement, for instance that the risk of surgery in a particularly heavy smoker was too great, then I would have no quarrel with it. If it was a moral judgement, then I believe the surgeons went too far. Doctors may decline to carry out procedures such as abortion on grounds of their religious or moral convictions, but I do not believe they have the right to withhold potentially beneficial treatment because the patient smokes, or drinks, or indulges in unprotected sex, or fails to wear a seat-belt when driving. This would be overplaying one's deistic role! The question has been asked whether, in a health service that is under severe financial constraint, doctors should offer elective surgery to patients who are at higher risk of complication or who stand a lower chance of success as a result of harmful personal practices such as smoking or alcohol abuse. I hope doctors will make such decisions on their judgement of benefit v. risk, not as part of a financial accounting process.

The problem of the allocation of funds for medical services is bound to become a key issue in the South Africa of the future. I am aware of the uneven distribution of doctors and other health professionals and of resources throughout the country, with a concentration in the cities and a dearth of services in more remote rural and less affluent urban areas. This sort of inequality is not exceptional; it is found in many developed countries as well as in the developing. It is not easy to achieve an even spread of high-quality services throughout a large and relatively unpopulated country. In Britain it has been achieved because the country is small and heavily populated, so that services can with justification be established in many smaller towns that drain a substantial number of patients from a relatively small area. The existence of a central national health service that regulates the location of all hospital and general practice jobs makes the task a lot easier. I have been impressed by the system that exists in Malaysia in which compulsory government service is imposed on all medical graduates, many of whom are obliged to serve in under-doctored remote areas. This might seem Draconian, but some such obligation may need to be considered here to ensure a more equitable distribution of medical resources. This problem of distribution of health care and decisions about its priorities will be of paramount importance in the future; it will not be easy to solve.

The dilemma of State-employed doctors

Special problems arise when doctors are employed by the State and might see themselves as having dual responsibilities, to their patients and to their employers. This brings me to the Biko doctors and their extraordinary complicity in his maltreatment. I know this subject has been discussed, debated and written about to an inordinate extent in South Africa, but it is hard to ignore in a memorial lecture to Steve Biko. A number of recent publications have examined the involvement of doctors in torture — from Amnesty International,[3] the British Medical Association[4] and the Institute for Medical

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Ethics.[5] The spectrum of medical involvement ranges from certifying a subject fit for torture (or for capital punishment — seen by many as being equivalent to torture), to reviving a person who has been tortured, conniving or actively participating in torture or, simply, failing to take appropriate action when torture is known or suspected to have occurred. The moral content of some of these issues is complex. The proper response, of course, is to condemn *all* such abuses; connivance in any form should not be condoned. The issues, however, are not always straightforward. In individual cases, extreme pressure might be put on a doctor to collaborate through threats to him or his family. Doctors who do collaborate are often convinced of the moral justification for their actions — 'we are at war' or 'I'm only doing my job'. Central to acceptance of torture or other forms of abuse is dehumanisation of the victim, reduction to subhuman status; in the South African context, after decades of racialist propaganda any militant black opponent of apartheid is likely to have been viewed in this light by those who worked to uphold the system. In the same way Jews, gypsies and homosexuals came to be regarded as '*untermenschen*' by Nazi extermination squads.

I do not equate what has happened in South Africa with the events of Nazi Germany. It is not just a matter of degree. Policies of racial hygiene that encompassed sterilisation, mass euthanasia and genocide have not been pursued in South Africa and would not have been tolerated other than by a handful of psychopaths. What is interesting in the history of Nazism is the eagerness with which so many German doctors supported policies to purify the community. They joined the Nazi party earlier and in greater numbers than any other professional group. By 1942 half of all doctors had joined the Nazi Party, even by 1937 they were represented in the SS seven times more than the average. The concept of 'racial hygiene' ('ethnic cleansing' in modern terms) was invented by doctors and medical scientists. I shall not dwell on the active participation of doctors in callous human experimentation or in devising more efficient techniques of mass killing. I doubt if even the most rabidly racialist doctor in South Africa would have gone so far.

I do not know what motivated Lang or Tucker. I do not believe they were clinically incompetent or ignorant and, while they might have felt their jobs were in jeopardy, they almost certainly had little else to fear in the way of reprisal. In cross-examination by Advocate Kentridge,[6] Lang and Tucker admitted that the interests of the patient (Biko) had been subordinated to the interests of society, in this instance the security police acting as society's agents. Even if they believed this, one has to wonder what happened to their sense of compassion or regard for human suffering, quintessential characteristics of all normal caring doctors. Where was their professional — or personal — conscience?

Blowing the whistle

Recently the late Dr Jonathan Gluckman decided he had had enough and spoke out against the brutal treatment of prisoners. It is reported that he had dealt with over 200 bodies of people who died in police custody. According to the *British Medical Journal*,[7] he failed to speak out earlier because 'it was not my place'. I know that he displayed great courage in finally breaking his long-maintained silence, and I know that he tried hard to put a stop to abuses by working 'within the system'. It has also been reported recently by Alistair Sparks that it was Dr Gluckman who originally leaked the truth about Biko's injuries to the press, and this was a very risky thing to do. So, I do not question his integrity or courage; I do question his judgement. I believe it *was* his 'place' to speak publicly about the abuses he knew about. One can't help wondering how many deaths, how much suffering might have been avoided had he or Lang or Tucker or many other unidentified doctors spoken out when they encountered such brutality. Wendy Orr did what I believe they should have done. She made her protest about the maltreatment of detainees because she felt she would otherwise be compromising her moral beliefs and her perception of her professional responsibility. 'My conscience told me I could no longer stand by and do nothing.' Surely, the point of resolution in such conflicts between one's duty to one's profession and to the State is one's personal conscience, and I remain convinced that a single-minded conscientious commitment to the interests of our patients must be the cornerstone of our professional conduct.

In some circumstances it would take great courage and moral integrity to speak out. In Chile, Romania and the Soviet Union, for instance, doctors have been jailed for refusing to cover up for torture; as recently as 1989 doctors in the Sudan were charged with high treason when they protested about human abuse. The Tokyo Declaration of 1975 explicitly requires a doctor to denounce any cases of torture which come to his notice. This may be a counsel of perfection but it is to be expected. Doctors who do have the courage to speak out must not be left in isolation to bear reprisals. Local or national medical organisations, as defenders of medical standards, have a duty to protect such whistle-blowers and support them against police or State retribution. In this regard the medical profession in South Africa was let down badly by its representative body, the Medical Association of South Africa, and the upholder of its standards, the South African Medical and Dental Council. Nothing could have done more damage to the cause of South African medicine in the eyes of the world than the deplorable lack of principle shown by these two bodies. It is worth noting that years later the MASA failed to give proper support to Dr Orr when she made her protest, and that the SAMDC wasted no time in taking disciplinary proceedings against Dr Aubrey Mokoape when he came out of prison after serving a sentence for political activities.

I do wish to pay tribute to those doctors who, in one way or another, did object to what was happening and I can only express my deepest admiration for the legal actions taken by Frances Ames, Trefor Jenkins, Phillip Tobias and, separately, Drs Veriava, Mzamane and Wilson to force the SAMDC properly to discharge its functions. I pay tribute, too, to this medical school and to the Vice-Chancellor, Dr Saunders, for their efforts to put things right in this tragic saga.

If I may be excused a small personal tribute to Frances: I saw her first one evening, when as a slightly bored fresher at Men's Res, I wandered up to the Union to attend a student meeting. I've forgotten the topic, but at some stage Frances, then a senior medical student, appeared on the platform with a young black student and quietly and cogently pointed out how difficult it was for him to attain the educational goals that we all took for granted, accepted almost as our right. That was well over 50 years ago — it was my first lesson on the inequalities of life in South Africa and I have always been grateful to Frances for beginning to open my eyes.

Boycotts — right or wrong?

Mention of Phillip Tobias's name inevitably reminds me of his exclusion from the World Archaeological Congress held in Southampton in 1985. I have long been an admirer of Professor Tobias — a renowned scholar and an outspoken opponent of injustice in South Africa — and I confess to misgivings over this issue. For many years, going back well before I left South Africa in

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1968, I have been pro-boycott. I shall not try to cover the arguments that surround this vexed question — whether it should apply to medical or scientific or academic affairs in general. I came to support a comprehensive boycott after much thought and heart-searching and was finally persuaded by the views of my black politically aware friends. Almost all favoured sanctions, in words perhaps exemplified by Chief Luthuli in 1962:[8] 'The disapproval and ostracism of other countries will have the effect, if properly directed, of shortening the day of bloodshed and bondage . . .. I shall not argue that the economic ostracism of South Africa is desirable from every point of view. But I have little doubt that it represents our only chance of a relatively *peaceful* transition from the present unacceptable type of rule to a system of government which gives us all our rightful voice.' He added 'the suffering to us will be a price we are willing to pay'. Steve Biko urged the USA to 'start getting tough — sanctions, blockade if necessary — the lot' and added 'we blacks reject the theory that sanctions will harm us more'.[9] Luthuli and Biko — and many more recent black leaders — rejected the 'this will hurt you more than us' argument. In his essays on Liberty Isaiah Berlin[10] pointed out the fallacies and dangers of the plea 'Do what I say because I know what is best for you'. I have a feeling that this self-comforting argument was applied heedlessly in South Africa. Those at the low end of the totem pole had little to lose from the application of sanctions, and much to gain. The debate about the morality of sanctions, especially as applied to medicine, education and the arts has, at times, shown a confusion about motives. Many doctors and academics and artists refused to come to South Africa not on ethical grounds, simply because they found the system abhorrent and preferred not to take any part in it whatsoever; others came and were so appalled by what they saw that they vowed never to return. In these cases the motivation was not broadly moralistic, nor was it political, it was a matter of personal taste. I came to share this view when years before I left South Africa I gave up going to segregated cinemas and theatres, not as a matter of principle — I just felt uncomfortable being part of a whites-only audience; it didn't strike me as, nor was it meant to be, an ethical action or statement. In the same way to me sanctions have always been more of a pragmatic issue, in the Luthuli/Biko sense, than an ethical issue. Black opponents of apartheid viewed sanctions as a weapon in the fight against it, not as a moral dilemma, the loftiness of which could hardly have concerned them. I have a suspicion that events have justified this view, that comprehensive (but admittedly incomplete) sanctions and ostracism did play a part in initiating the transition that is now taking place.

Doctors and politics

This question of the inclusion of medicine as part of the weaponry against apartheid and injustice brings me to the final question I wish to discuss. Do doctors have some special reason to be involved in broader political issues? As individuals or as a profession do we have a special interest in the provision of justice and fairness in society? Do we have special cause to be concerned with forces that threaten or tend to destroy the health of our community or, indeed, our planet?

I believe we do. I confess I didn't start off feeling this way. My awareness of broader issues and my ultimate political involvement were slow and insidious processes that owed their origins to many circumstances: coming to UCT from the Eastern Province and hearing for the first time the views of people like Frances Ames; my years in the army exposed not only to the horrors and wastefulness of war, but to the atmosphere of liberalism that was abroad at the time and, serving as a private, my first experience of taking orders not giving them, and of making friends with men whose backgrounds were far less privileged than my own; later, meeting people who had been tortured in police custody or had suffered serious psychological damage after solitary confinement; at Groote Schuur Hospital my awareness that many of our patients had diseases that should have been prevented or treated earlier and of the prevalence of malnutrition; the friendships I developed with black South Africans that led me gradually to see life and events from their angle and to feel anger at the humiliation and cruelty they suffered simply because they were born a different colour, and my sense of frustration that most white South Africans seemed blind to the harm they were doing.

Medicine is a caring profession. If we care about our patients, we should care about humanity. This explains the emergence of important post-war medical organisations such as Physicians for Social Responsibility in the USA, International Physicians for the Prevention of Nuclear War, the Medical Foundation for the Care of Victims of Torture, and Medical Action for Global Security (MEDACT) in Britain, over which I have had the honour of presiding. In these organisations concern has been expressed about wider societal issues, such as the threat of nuclear war or war, in general; if for no other reason, because so much money is diverted to military expenditure that could be used to improve world health (in 1990 almost $1 000 billion was spent; 35 seconds of this would have fed over 20 000 people for a year, 7 days would have eliminated world hunger); or, about Third-World debt, as a result of which UNICEF estimates 500 000 children die unnecessarily each year; or about environmental issues that render the earth unsafe, unhealthy or unproductive.

Of course these are medical issues; if we as doctors take no interest in these crucial matters of public health, who do we think will do so? And in South Africa black poverty and lack of education and housing were — and still are — medical issues.

Steve Biko saw this quite clearly when he gave up his medical studies. As Lindy Wilson says, 'The choice he made was one that thousands of black students would come to face: the choice of either becoming a political activist or taking the time to gain some sort of qualification toward a professional life'.[9] Biko decided to sacrifice his career as a doctor and this, tragically, led to the sacrifice of his life.

From my distant vantage-point and with my admittedly limited knowledge of what's really happening in South Africa, I feel optimistic. I sense a will — on all sides — to build a new and just and equitable society. I hope it will succeed. Steve Biko's life and death have, in a curious way, helped to bring this about. How sad it is that he is not here to play his part.

SIR RAYMOND HOFFENBERG

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